STATE HEALTH BENEFIT PLAN (SHBP)
2011 NON-TOBACCO USERS AFFIDAVIT FORM
(RETIREES UNDER AGE 65)

Policyholder/Plan Member Name:_____

Social Security Number:_____

Health Plan Options: (circle one) CIGNA HDHP, CIGNA HMO, CIGNA HRA,

UHC HDHP, UHC HMO, UHC HRA

Check all of the following:

☐ I hereby certify that all covered members have not used any tobacco products within the past 12 months

☐ I hereby certify that all applicable covered members have completed a health assessment during this plan year

☐ I hereby certify that all applicable covered members have completed an online or telephonic wellness program with the above health plan

☐ I understand that as a State Health Benefit Plan member I have the responsibility to read the current Decision Guide and the Summary Plan Description of my chosen health plan option

☐ I understand it is my responsibility to access the open enrollment website **OR** must complete a personalized change form each year to make elections and answer the surcharge questions to prevent default surcharges

☐ I also understand that this document must be completed, all boxes checked and returned to SHBP at P.O. Box 1990, Atlanta, GA. 30301-1990. The effective date of the change will be dependent upon the date SHBP receives this form. No refund in premium(s) will be made for any previous deductions that included the surcharge amounts. The Internal Revenue Service rules require all premium charges to be prospective.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further understand that I will permanently lose my SHBP coverage if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health (DCH) regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20. I also understand that I will not be eligible to re-enroll unless I return to work in a benefits eligible position in which SHBP coverage is offered.

Signature_____ **Date** _____

Note: Once you have read and signed this affidavit you must submit it to SHBP. If this form is received without a signature and all boxes checked, it will be returned to you for completion and will delay processing.